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# The changing role of the tissue viability nurse: an exploration of this multifaceted post

## KEY WORDS

- » Quality
- » Role
- » Skills
- » Tissue viability nurse

This article explores the role of the tissue viability nurse in the UK and discusses the diversity of the role and key attributes and skills required to run a successful service. The article highlights that services differ between organisations and that there is a lack of clarity of the core functions of the role published in the literature. This is compounded by an absence of valid and reliable tools that can be used to measure the effectiveness of the tissue viability service. This article suggests it is now time to revisit the tissue viability role and explore the competencies required, and offer guidance as to the qualifications required for this multifarious post to enable staff to manage the changing needs of a diverse patient group.

During the past decade, the number of people in the UK aged over 65 has increased by 17.3% to 11.1 million, the fourth highest in the European Union (Office for National Statistics, 2014). With this increased ageing, and with a more multicultural population, it is fair to assume that tissue viability services will see an increase in workloads; be expected to care for patients with a range of comorbidities and complex wounds; and will be required to manage the changing needs of a diverse patient group. This article, therefore, explores the role of the tissue viability nurse (TVN) in the UK so as to understand the skills and knowledge required to deliver tissue viability services that can meet these changing needs effectively.

## DEVELOPING THE POSITION OF TISSUE VIABILITY NURSES

The role of the TVN is complex. It encompasses a range of healthcare specialities, including paediatrics, adults, older people, mental health, and learning disabilities. Tissue viability nurses are expected to possess specialist knowledge and skills to manage expertly a range of skin integrity issues, and to identify, appraise, analyse and implement up-to-date evidence-based findings into clinical practice.

As healthcare environments continue to change, it is fair to assume that the role of the TVN also has to adjust to ensure that the needs of patients and of their

carers, friends and family are being met. However, over the past decade, there has been little research on the complexities of this role.

During the 1980s, the number of TVNs rose steadily in response to the mismanagement of patients with wounds (Fletcher, 1995).

By the 1990s, results from a focus group of clinical nurse specialists ( $n=18$ ) (Flanagan, 1998a) revealed there was a disparity between conditions of employment, role expectations and preparation for practice for the tissue viability role.

In a literature review examining the development of the tissue viability specialism, Flanagan (1998b) concluded that although in the UK the TVN role was developing, it was haphazard and there was confusion between the terms 'specialist' and 'advanced nurses', which allowed employers to establish a range of standards relating to the specialist role.

A study in 2011 highlighted the ongoing complexity and diversity of the role (Fox, 2001). Respondents ( $n=87$ ) reported their role as being a TVN, yet there was a large percentage that identified other responsibilities including lecturer/practitioner and infection control nurse. This lack of consistency towards the competencies and the educational level required of the TVN role is still widespread in the present day.

## Setting the political agenda

Since Lord Darzi's report, *High Quality Care for*

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All (Department of Health [DH], 2008), and *High Impact Actions* (NHS Institute for Innovation, 2009), tissue viability services have been under pressure to measure the effectiveness of their services.

With the continuing movement to maintain and improve quality services in the NHS, and with the Health and Social Care Act 2012 increasing patient empowerment and choice, it has never been more significant for services to be able to measure patient and service outcomes, and to provide a cost-effective service that is able to articulate clearly its competencies and expertise.

### WHAT IS THE ROLE OF THE TISSUE VIABILITY NURSE?

White (2008) suggested that tissue viability does not have a scope that is defined or broadly accepted outside of nursing, and that it has an 'invisible' public and media profile. White (2008) also suggested that the root cause of this is lack of medical 'partnership', with no specific statements from the Royal Colleges on the role of tissue viability, on the physician/surgeon's responsibilities and on research in this area (with the exception of the Royal College of Nursing).

The National Association of Tissue Viability Nurse Specialists, Scotland, have developed a core competency framework (Finnie, 2003). The framework presents three core domains:

- ▶ Empowerment: the tissue viability nurse is expected to consistently identify situations of risk to individuals/groups and will respond appropriately
- ▶ Leadership: the individual will act as a consultant, implementing and disseminating change
- ▶ Professional practice: the individual will engage in ethical debate and demonstrate a functional knowledge of contemporary ethical issues relating to tissue viability.

The US has sought to clarify the skills and knowledge required of TVNs. There are differences between the UK and USA role; in the US the role of the TVN is combined with that of colorectal and continence nurse to create the umbrella role of wound, ostomy and continence nurse. The Wound Ostomy Continence National (WOCN) Certification Board (US) has set clear criteria required by applicants (see *Box 1*). This certification aims to protect the public from unsafe and incompetent providers, provide consumers more options when choosing health care providers,

and distinguishes the healthcare facility and administrators by providing expertise in wound, ostomy, continence and foot care (Wound Ostomy Continence National Certification Board, 2014).

Protection of the public and provision of evidence-based safe care is integral to the delivery of care in the UK, yet at present, in regards to tissue viability, there is very little to measure expertise against.

### DEFINING THE ROLE

The focus on the prevention of pressure ulcers as part of the Commissioning for Quality and Innovation targets (DH, 2010) has made tissue viability services more visible. The current role of the TVN in the UK is complex and encompasses a range of skills. However, there is no universally accepted national role definition or knowledge and skills framework from which to benchmark services.

Generally, tissue viability focuses on preventing insults to the skin and underlying tissues, and facilitating healing in wounds where a complication has prevented the normal healing process.

However, even this definition falls short of describing the full complexity of the role, as presented in *Figure 1*. The complexities of the role are further presented in *Table 1* using wound types to identify the specialties that may be part of the team caring for the patient.

Ideally, all services would work seamlessly together. However, in reality, the patient journey can become protracted as there is no structured central coordinator of care. Tissue viability teams often become the coordinator of care as part of the continuing healthcare agenda, in partnership with district nursing and general practice.

### CURRENT ROLES OF TVN AND TISSUE VIABILITY SERVICES

#### Patient-centred care

Maintenance of skin integrity to reduce further harm to a patient requires vigilance. Prevention is the ultimate aim, however, where this is not possible correct diagnosis and management is the secondary aim.

The TVN is required to draw on specialist knowledge and skills to guide other healthcare specialists in the care of complex wounds.

The International Alliance of Patients' Organisations (2007) suggests that, irrespective of specialism, patient care has five common attributes:

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**Box 1. Requirements by the Wound Ostomy Continence National Certification Board (2014).**

- Have a current registered nurse licence
- Hold a bachelor's (or higher) degree
- Have completed one of the following pathways of education or practice:

**Traditional pathway**

- Graduate from an accredited wounds ostomy continence (WOC) nursing education programme
- The WOC nursing education programme must have been completed within the past five years
- The WOC nursing education programme must be accredited by the WOCN Society at the time of graduation

**Experiential pathway**

- The accumulation of direct patient clinical hours and continuing education credits (contact hours) must be earned post-bachelor's degree while practicing as a registered nurse
- For each specialty for which certification is sought, 50 contact hours or an equivalent in college course work must be completed over the five years previous to the date of application. All contact hours or college course work must directly apply to the specialty area for which applied
- For each certification specialty, 1,500 direct patient clinical hours must be completed within the previous five years. Further, 375 hours must have occurred within the year before application.

If this criteria has been met, candidates will be required to sit an exam.

- ▶▶ Respect of a patient's unique rights and values
- ▶▶ Choice and empowerment to make informed decisions about health that focus on achieving the best possible quality of life
- ▶▶ Patient organisations deserve the right to share the responsibility for shaping health policy
- ▶▶ Access and support to services warranted by their condition
- ▶▶ Access to accurate relevant and comprehensive information.

Arguably these key attributes could be measured in a quality service.

**Patient safety**

Care interventions delivered by TVNs are not only concerned about the practicality of managing patients' skin integrity, but also encompass the need to recognise areas where patient safety is compromised and seek to minimise the impact of both the environment and interventions on these (as outlined in *Safety Thermometer* [NHS, 2014a]).

Outcome indicators form part of the day-to-day vocabulary of the health service, including reduction of avoidable pressure ulcers, outlined in *Improving Quality Patient Safety Programme* (NHS, 2014b).

Trusts identify pressure ulcers as 'clinical incidents'. TVNs are involved in the investigation of these incidents, sharing the learning and implementing prevention plans to minimise further risk. These may include the introduction of care pathways, specification of equipment,

and liaising with procurement departments to address needs, or increasing education to address knowledge gaps. The impact of these plans are assessed via audit or outcome monitoring after introduction. However, this is not limited to pressure ulceration; tissue viability teams also share responsibility with infection control teams and surgical specialties to reduce and monitor surgical site infection rates, and to monitor the impact of lower limb cellulitis admissions.

**Education**

Integral to the TVN role is developing local education programmes for all healthcare professionals within Trusts. These programmes need to be appropriate to the level of knowledge and responsibilities of the multidisciplinary team. Most TVNs typically participate in postgraduate courses, and attend study days and conferences that seek to equip practitioners with the knowledge and skills to manage patients with compromised tissue viability. This allows TVNs to support ongoing learning and cascade this new knowledge to novice tissue viability staff. This is an essential element of the registered practitioner's role. The Nursing and Midwifery Council (NMC, 2010) state that care delivered must be based on the best available evidence or best practice and that all registered practitioners must ensure that any advice given is evidence-based, especially if healthcare products or services are being suggested.

**Table 1. Specialities currently involved in the care of patients with compromised skin integrity.**

Dermatology	Vascular	Podiatry	Plastics	Burns	Lymphoedema	Surgical	Tissue Viability Services
<ul style="list-style-type: none"> <li>• Malignancy</li> <li>• Vasculitis</li> <li>• Eczema and dermatitis</li> <li>• Allergy screening</li> <li>• Hidradenitis suppurativa</li> <li>• Factitious disorder*</li> </ul>	<ul style="list-style-type: none"> <li>• Peripheral arterial disease/ ischaemia and intervention</li> <li>• Venous screening and intervention</li> </ul>	<ul style="list-style-type: none"> <li>• Foot ulceration†</li> <li>• Neuropathic</li> <li>• Ischemic‡</li> <li>• Rheumatoid</li> <li>• Structural deformity*</li> </ul>	<ul style="list-style-type: none"> <li>• Pilonidal sinus#</li> <li>• Leg ulcer</li> <li>• Extensive skin tears</li> <li>• Trauma§</li> </ul>	<ul style="list-style-type: none"> <li>• Initial care of all burns and scalds</li> </ul>	<ul style="list-style-type: none"> <li>• Primary lymphoedema</li> <li>• Secondary lymphoedema</li> </ul>	<ul style="list-style-type: none"> <li>• Post-operative complications (for example, wound dehiscence)</li> <li>• Abdominal wall reconstruction</li> </ul>	<ul style="list-style-type: none"> <li>• Venous ulceration‡</li> <li>• Varicose</li> <li>• Eczema</li> <li>• Arterial ulceration‡</li> <li>• Pressure ulcers</li> <li>• Acute wounds</li> <li>• Skin tears</li> <li>• Moisture lesions‡</li> </ul>
<p><b>Effective management of patients with wounds requires integrated pathways and partnership from services:</b></p> <p>* In partnership with psychology            † In partnership with diabetologists and diabetic nurses            ‡ In Partnership with vascular            # In partnership with orthotics            § In partnership with orthopaedics            ¶ In partnership with continence nurses            Mixed aetiology leg ulcer patients often span multiple services, most often a mixture of vascular, lymphoedema and tissue viability.</p>							
<p><b>Other specialities involved in wound care:</b></p> <ul style="list-style-type: none"> <li>• Dietetics: all patients with compromised nutrition that is impacting wound healing should have a referral made to a dietician</li> <li>• Bariatric services/surgery: to successfully manage wounds in this patient group it is essential to address the underlying cause</li> <li>• Ergonomics: often required in complex patient management and pressure ulcer management cases to find solutions to moving and handling</li> <li>• Equipment services: to ensure the timely provision and ongoing maintenance of preventive equipment</li> <li>• Occupational therapy/physiotherapy for rehabilitation, home adaptation of specialist equipment (for example wheelchair services)</li> <li>• Immunology and infectious diseases: some patients are referred for advice.</li> </ul>							

**Resource management**

Tissue viability is involved in shaping overarching service provision. For example, in partnership with procurement departments, tissue viability services define the specification and award contracts for the provision and management of pressure redistributing equipment. This includes the management of both purchased and rental equipment, both in primary and secondary care, to ensure that the equipment available meets the needs of the patient and is appropriate to the patient environment. Therefore, knowledge of a wide range of equipment is needed to provide this service effectively, as well as regular audit to ensure that the equipment is fit for purpose. The ability to develop a business case to secure funding for purchases is also needed.

**Cost effectiveness management**

The importance of providing a service that not only meets the needs of the patient but is also cost-effective cannot be underestimated. There are a plethora of wound dressing products available for managing wounds, and the TVN must ensure that

products chosen are appropriate and cost effective. An essential aspect of the role is producing a wound care formulary that not only provides wound management products to facilitate the healing of all types of wounds, but that is also cost-effective by helping avoid hospital admissions or reduce length of stay. This requires advanced knowledge of all available products and their mechanism of use.

**Research**

Evaluation of care interventions, case studies, audit, and involvement in national initiatives should underpin the TVN role. For example, collation of formulary compliance data, mattress audits, surgical site infection surveillance and patient satisfaction surveys, as well as service audit, all will assist in providing justification for ongoing provision.

Tissue viability services are also responsible for ensuring Trust compliance with national and European guidance on aspects of tissue viability by developing policy procedures that are disseminated and adopted locally. This may take the form of leg ulcer, wound management, pressure ulcer prevention and management policies, or by contributing to

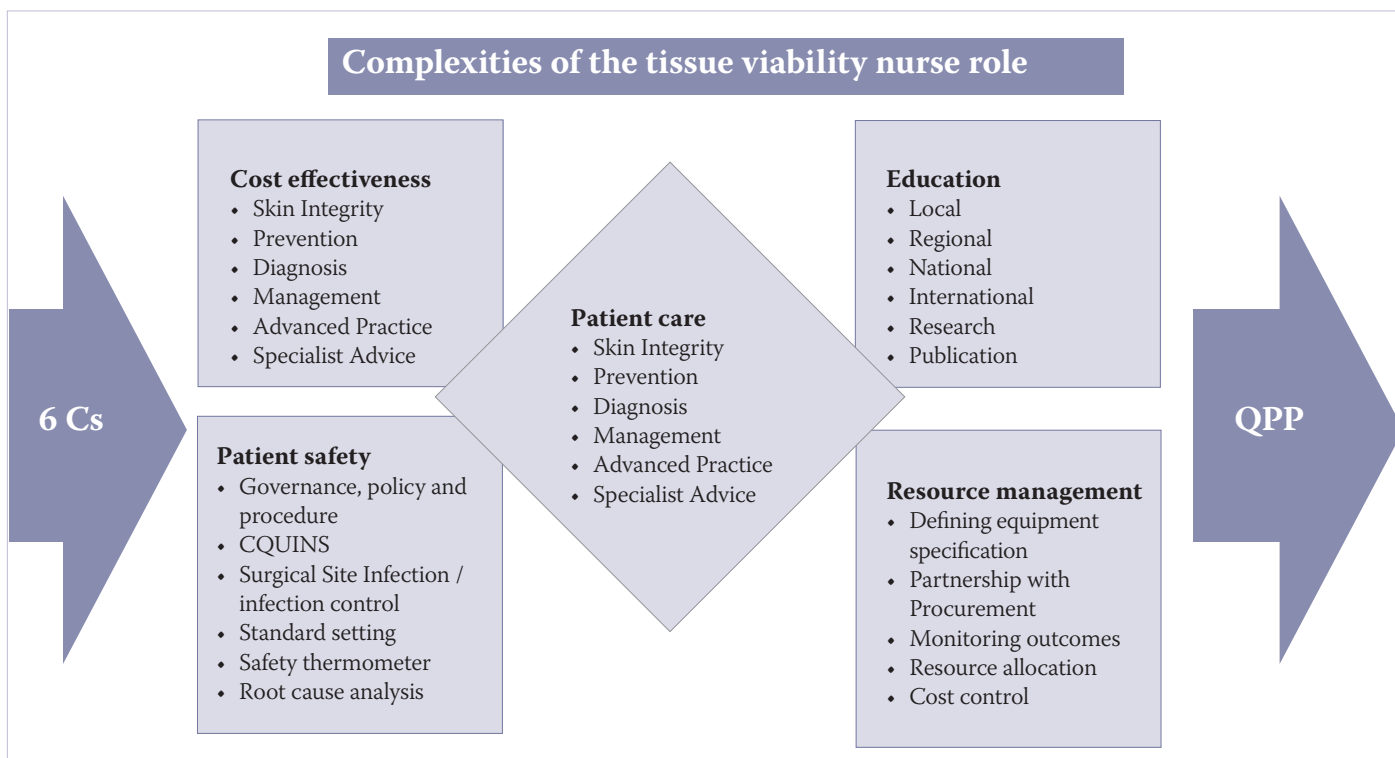


Figure 1. Diagram to represent the complexities of the tissue viability nurse role.

other documents, such as the safe use of medicines in relation to prescribing of dressings and other medicines used in wound care.

**DISCUSSION**

The range of skills and knowledge required of the TVN is multifaceted. The TVN role is integral to effectively managing a variety of tissue viability issues. An effective tissue viability service can:

- ▶▶ Improve patient outcomes through prevention and early identification of infection
- ▶▶ Reduce non-elective hospital admissions through specialist treatment administered in the community
- ▶▶ Reduce spend in relation to disposables and consumables, ensuring innovative products are used appropriately, and that there is appropriate prescribing delivered through an evidence-based wound care formulary.

However, despite this there is a lack of definition of the TVN role and an absence of valid and reliable tools that can be used to measure the effectiveness of the tissue viability service. Difficulties arise from a lack of standardised audit tools from which to work with.

There are no nationally accepted job descriptions that incorporate the totality of the TVN post with the diversity of pay bands across

the UK, ranging from band 5–8 and above, further complicating understanding of the post.

The authors of this article suggest the need to reconsider the educational standards required of the post holder; if the post demands business acumen in addition to clinical skills and knowledge, should a TVN be expected to hold a business degree? The TVN is also expected to be able to critically understand, analyse, appraise and implement relevant research into clinical practice, therefore, should candidate, as a minimum, hold a Master’s qualification?

In addition, the specification for tissue viability services varies between areas, making it difficult to benchmark what a good service should be. For example, is a good service one that shares a common vision, has a mission statement that is used along robust referral criteria with appropriate triage to knowledgeable staff in a timely manner? Or is a successful service purely one that writes the policy elements and teaches staff adherence?

It could be argued that activity is largely dependent on the size of the team in relation to the size of the organisation and, as such, while some teams may aspire to provide all services, the focus has to be on achieving outcomes for the greater good of the majority. If we cannot define ‘good’, how can we set key performance indicators? Ultimately,

without clear definitions, tissue viability cannot measure success or set aspirational goals.

**CONCLUSION**

The role of the TVN is diverse, with no standard recognised job description. The health service is in rapid change, with patients, carers, family and friends expecting high quality care delivered by knowledgeable professionals who can ‘prove’ that the chosen interventions are of a high quality. TVN must rise to the challenge and prove that their role effectively meet the changing environment.

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